Alta Vista Wellness Center
414 Shiloh Drive Unit 9 Laredo Texas 78045
Phone (956) 791-8235 Fax (956) 791-8239

Today's Date:

New Patient Registration Form

PATIENT INFORMATION	
Last Name:	
First Name:	
Middle Name:	**Marital Status:**
Date of Birth:	**Social Security #:**
Age:	**Home Phone:**
Address:	**Cell Phone:**
	Work Phone:
Date of Injury:	**Email Address:**
EMPLOYER INFORMATION	
Employer Name:	**Occupation:**
Employer Phone:	**Address:**
Workers Comp. Claim #:	
EMERGENCY CONTACT	
Name:	**Relation to Patient:**
Home Phone:	**Cell Phone:**
SUBSCRIBER INSURANCE INFORMATION	
Name:	**Relation to Patient:**
Date of Birth:	**Social Security #:**
Phone Number:	

ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Alta Vista Wellness Center / ALGO Health Inc. I understand that I am financially responsible for any balance. I also authorize Alta Vista Wellness Center / ALGO Health Inc. or my insurance company to release any information required in processing my claims.

_____ _____

Patient / Guardian Name (Print) **Relationship to Patient**

_____ _____

Patient / Guardian Signature **Date**

Alta Vista Wellness Center
414 Shiloh Drive Unit 9 Laredo Texas 78045
Phone (956) 791-8235 Fax (956) 791-8239

Confidential Information Questionnaire

Please answer to the nest of your knowledge.

1. What brought you to physical therapy?

2. What limitations do you have because of your injury? (Explain)

3. Have you ever received any of the following (if so, please write dates received):

- ☐ **Physical Therapy** _____
- ☐ **Massage Therapy** _____
- ☐ **Chiropractic Therapy** _____
- ☐ **Athletic Training** _____
- ☐ **Personal Training** _____
- ☐ **Dr. of Osteopathy** _____

4. Last doctor's appointment:

5. Are you currently a home health patient? **YES or NO**

If yes, what is the name of the home health agency?

Initial	**PLEASE NOTE:** **If you are in a Home Health Agency you may be billed for services if your insurance denies coverage.**

5. What medications are you presently taking, if any? [Please include dosage (mg/times per day)]

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

6. FEMALE PATIENTS: Are you now or do you think you might be pregnant? YES or NO

7. Are you now or have you ever been treated for any issues with:

- ☐ Cardio Vascular (Heart)
- ☐ Lung (Respiratory)
- ☐ Kidney
- ☐ DM (Diabetes)
- ☐ DM II (Diabetes)
- ☐ Hypertension
- ☐ Cancer
- ☐ Allergies to Medication
- ☐ Other: _____

8. Have you had surgery for this injury? (YES or NO)

***If yes, please provide the date(s) of surgery** _____

_____

9. Please list any other surgeries you have had within the last 5 years (date and type)?

ACKNOWLEDGEMENT

The information contained in this questionnaire will be used to help determine the most appropriate physical therapy treatment required to help restore your highest functional ability. All information is considered confidential and will not be released unless prior written authorization is given.

I certify that the foregoing information is accurate and truthful to the best of my knowledge.

_____	_____
Patient / Guardian Name (Print)	**Relationship to Patient**
_____	_____
Patient / Guardian Signature	**Date**

Alta Vista Wellness Center
414 Shiloh Drive Unit 9 Laredo Texas 78045
Phone (956) 791-8235 Fax (956) 791-8239

Compliance Notice

Please READ and SIGN.	
Initial	**It is the policy of Alta Vista Wellness Center to give our patients the best care possible from Physical Therapy. Therefore, we acknowledge giving you the best possible treatment and in return requests that you abide with our compliance rule.**

I acknowledge to fulfill my part by complying with the home exercise program and scheduled visits. I further acknowledge and understand that IF I MISS 3 VISITS within the scheduled treatment dates, the PT may have deemed necessary to terminate treatment and I will be held responsible for any consequences with my physician and/or insurance company.

If I have a valid excuse I understand that I am to let Alta Vista Wellness Center know (1-2 days) in advance, unless it is an emergency (valid excuses include medical appointments or hospitalization, feeling sick or ill [with an excuse from my physician]).

Initial	**FAILURE TO NOTIFY our office of an appointment cancellation will cause me to incur a FEE OF $40.00 each time.**

ACKNOWLEDGEMENT

If at any time you cannot abide by our compliance policy, please let the Physical Therapist know, so we can refer you back to your doctor or insurance coordinator or insurance adjuster.

My signature or my assigned representative's signature below acknowledges that I understood and will abide by the schedules and home exercise program given to me to the best of my ability.

_____ _____

Patient / Guardian Name (Print) **Relationship to Patient**

_____ _____

Patient / Guardian Signature **Date**

Alta Vista Wellness Center
414 Shiloh Drive Unit 9 Laredo Texas 78045
Phone (956) 791-8235 Fax (956) 791-8239

Authorization for Treatment

Please read and sign

Physical Therapy is a patient care service provided in response to a wide range of medical care needs for outpatients of all ages 5 days a week regardless of gender, race, color, creed, nationality, or disability.

The purpose of Physical Therapy is to treat any disease, injury and disability by evaluation, examination, testing and use of rehabilitative procedures, manipulations or mobilizations, massage, exercise and physical agents [including but not limited to: mechanical devices, heat, cold, air, light, water, electricity, and sound. In the aid of diagnosis or treatment to obtain for the physician information needed in the diagnosis and evaluation of patients; to prevent or minimize residual physical and mental disability; aiding the patient in achieving their maximal potential within their capabilities; and to accelerate convalescence and reduce the length of the fictional recover]. Physical Therapy includes, but is not limited to, the use of: Transcutaneous Electrical Nerve Stimulation (TENS), Neuro Muscular Electrical Stimulation (NMES), bed traction, application of topical medication to open wounds, sharp debridement, and provisions of soft goods, inhibitive casting, splinting or taping, phonophoresis, iontophoresis and biofeedback services. All procedures will be thoroughly explained to you before you are asked to perform them.

You are not to experience any increase in your current level of pain or discomfort or issue. You should attempt to stop each procedure before you experience any increase in your current level of pain or discomfort.

You are expected to cooperate fully with the evaluation and stop any test or treatment before any increase in your current level of pain or discomfort. You should attempt to stop any procedure before you experience an increase in your current level of pain/discomfort.

Due to the nature of services provided you might be asked to disrobe or partially disrobe – your privacy, modesty and dignity will be considered, at all times, by our staff. If at any time you feel uncomfortable or embarrassed, you reserve the right to refuse the procedure and/or request another therapist.

There are certain inherent risks with Physical Therapy treatment. You will be asked to exert effort and perform activities with increasing degrees of difficulty that could cause an increase in your current level of pain or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small, and you will be able to stop treatment at any time if you feel any discomfort in any other part of your body. The Physical Therapist/ Physical Therapist Assistant will take every precaution to ensure that you are protected from any potentially hazardous situation. You will **NEVER** be forced to perform any procedure that you do not wish to perform.

Due to the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. **Alta Vista Wellness Center reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you received the maximum therapeutic value from the treatment.**

The law requires all staff members to report any evidence of abuse, neglect, and/or exploitation of patients.

Should you observe any abuse, neglect and/or exploitation, by an individual in the clinic, you are encouraged to report it immediately. If you wish to file a complaint or grievance for any reason you will be provide, in written form, with the names and addresses of appropriate individuals/ protective agencies; if necessary, you will be given appropriate privacy to complete your communication with those individuals/agencies.

Based on the above information, I agree to cooperate fully and to participate in all Physical Therapy

ACKNOWLEDGEMENT

procedures and to comply with the plan of care as it is established. I have read and understood the Authorization of Treatment and authorize the release of medical information to the appropriate third parties.

_____	_____
Patient / Guardian Name (Print)	**Relationship to Patient**
_____	_____
Patient / Guardian Signature	**Date**

Alta Vista Wellness Center
414 Shiloh Drive Unit 9 Laredo Texas 78045
Phone (956) 791-8235 Fax (956) 791-8239

Service Agreement/ Payment Plan Form

Please Read and Sign.	
Initial	Current regulations require that our office to notify you orally and/or in writing of any changes in payment required by the client no later than **30 calendar days from the date** Alta Vista Wellness Center becomes aware of the changes.

Payment Source:

___Cash / Check **___ Insurance** **___ Medicaid**

___Credit Card **___Medicare** **___Worker's Compensation**

ACKNOWLEDGEMENT

I _____ understand that I am financially responsible for non-covered services such as hot packs or procedures that my insurance does not cover under my plan.

I also understand that I have a deductible to meet each year and that I am financially responsible for this deductible.

I understand that my insurance has certain limitations in the number of visits that will be covered in Physical Therapy. If therapy must be continued beyond what my insurance coverage, I will have to make payment arrangements with Alta Vista Wellness Center/ ALGO Health Inc.

I certify that the above has been explained to me and I understand that I am liable for the cost of service that my insurances do not cover.

_____ _____

Patient / Guardian Name (Print) **Relationship to Patient**

_____ _____

Patient / Guardian Signature **Date**

Alta Vista Wellness Center
414 Shiloh Drive Unit 9 Laredo Texas 78045
Phone (956) 791-8235 Fax (956) 791-8239

Patient Photograph/Video Consent Form

Please read and sign.

I hereby acknowledge that I have been advised that photographs may be taken of me or parts of my body during therapy. The photographs will be taken by one of the members of **Alta Vista Wellness Center** staff. I hereby give my consent for **Alta Vista Wellness Center** to use the photographs under one of the following circumstances:

Please initial one of the following:

Initials

Internet: Photographs taken of me or parts of my body as well as details regarding my physical therapy services that I have received at Alta Vista Wellness Center, can be used on the company's website/social media in order to inform the public about physical therapy. Further, I release and discharge Alta Vista Wellness Center, any employees of Alta Vista Wellness Center, and the American Physical Therapy Association; and all parties acting under the license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

Initials

All Media: Photographs taken of me or parts of my body as well as details regarding physical therapy services that I have received at Alta Vista Wellness Center, can be used in any print or broadcast media including, but not necessarily limited to newspapers, pamphlets, educational films, internet, television, in order to inform the public about physical therapy methods. Further I release and discharge Alta Vista Wellness Center, any employees of Alta Vista Wellness Center, and the American Physical Therapy Association; and all parties acting under their license and authority, from any and all claims or actions that I have or many have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding physical therapy services rendered to me, including any claim for payment, in connection with any such use or publications. I give my consent as a voluntary contribution in the interest of public education and marketing, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

Initials

Physical Therapy Care Only: Photographs taken of me or parts of my body can be used solely for the purpose of my physical therapy with Alta Vista Wellness Center. The photographs and all details regarding physical therapy services rendered to me will be kept confidential within my personal medical history file at Alta Vista Wellness Center.

ACKNOWLEDGEMENT

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

_____	_____
Patient / Guardian Name (Print)	**Relationship to Patient**
_____	_____
Patient / Guardian Signature	**Date**

Alta Vista Wellness Center
414 Shiloh Drive Unit 9 Laredo Texas 78045
Phone (956) 791-8235 Fax (956) 791-8239

Health Information Privacy Notice

Please read and sign

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

ALTA VISTA WELLNESS CENTER is committed to protecting the privacy of medical information we create or obtain about you. This Notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to: (i) make sure your medical information is protected; (ii) give you this Notice describing our legal duties and privacy practices with respect to your medical information; and (iii) follow the terms of the Notice that is currently in effect.

WHO WILL FOLLOW THIS NOTICE

The privacy practices described in this Notice will be followed by all health care professionals, employees, medical staff, trainees, students and volunteers of **ALTA VISTA WELLNESS CENTER** specified at the end of this Notice.

HOW MAY WE USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following sections describe different ways we may use and disclose your medical information. We abide by all applicable laws related to the protection of this information. Not every use or disclosure will be listed. All the ways we are permitted to use and disclose information, however, will fall within one of the following categories:

Treatment. We may use or disclose medical information about you to provide you with medical treatment or services. We may also share medical information about you with other **ALTA VISTA WELLNESS CENTER** personnel or non-**ALTA VISTA WELLNESS CENTER** health care providers, agencies or facilities in order to provide or coordinate the different things you need.

Payment. We may use and disclose medical information about you so that the treatment and services you receive at **ALTA VISTA WELLNESS CENTER** may be billed to you and payment collected from you, an insurance company or another third party. For example, we may need to give information to your health insurance company about treatment you received at **ALTA VISTA WELLNESS CENTER**, so your health insurance company will pay us or reimburse you for the therapy.

Health care operations. We may use and disclose medical information about you for **ALTA VISTA WELLNESS CENTER** operations. These uses, and disclosures are made to enhance quality of care. For example, we may disclose information to Physical Therapists (PT), Physical Therapy Assistants (PTA), and Physical Therapy Technicians (PTT) for performance improvement and educational purposes.

Health information exchange. We may share information that we obtain or create about you with other health care providers or other health care entities, such as your health plan or health insurer, as permitted by law, through Health Information Exchanges (HIEs) in which we participate. For example, information about your past medical care and current medical conditions and medications can be available to us or to your primary care physician or hospital, if they participate in the HIE as well. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions.

Fundraising activities. We may contact you to provide information about **ALTA VISTA WELLNESS CENTER**-sponsored activities, including fundraising programs and events. For this purpose, we may use your contact information, such as your name, address, phone number, the dates on which you received treatment or services at **ALTA VISTA WELLNESS CENTER,** your treating PT/PTA/PTT name, your treatment outcome and your health insurance status. If we do contact you for fundraising activities, the communication you receive will have instructions on how you may ask for us not to contact you again for such purposes, also known as an "opt-out."

Additional uses and disclosures of your medical information. We may use or disclose your medical information without

your authorization (permission) to the following individuals, or for other purposes permitted or required by law, including:

- To tell you about, or recommend, possible treatment alternatives
- To inform you of benefits or services we may provide
- In the event of a disaster, to organizations assisting in a disaster- relief effort so that your family can be notified of your condition and location
- As required by state and federal law
- To prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person
- To the military if you are a member of the armed forces and we are authorized or required to do so by law
- For workers' compensation or similar programs providing benefits for work-related injuries or illnesses
- To governmental, licensing, auditing and accrediting agencies
- To third parties referred to as "business associates" that provide services on our behalf, such as billing, software maintenance and legal services
- Unless you say no, to anyone involved in your care or payment for your care, such as a friend, family member, or any individual you identify
- For public health purposes
- To courts and attorneys when we get a court order, subpoena or other lawful instructions from those courts or public bodies or to defend ourselves against a lawsuit brought against us
- To law enforcement officials as authorized or required by law

Other uses of medical information. Other uses and disclosures of medical information not covered by this Notice will be made only with your written authorization. Additionally, with certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your medical information without your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke (withdraw) that authorization, in writing, at any time. However, uses and disclosures made before your withdrawal are not affected by your action and we cannot take back any disclosures we may have already made with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

The records of your medical information are the property of **ALTA VISTA WELLNESS CENTER**. You have the following rights, however, regarding medical information we maintain about you:

Right to inspect and copy. With certain exceptions, you have the right to inspect and/or receive a copy of your medical and billing records or any other of our records that are used by us to make decisions about you. You have the right to request that we send a copy of your medical or billing records to a third party. You are required to submit your request in writing to your caregiver or the appropriate medical records department. We may charge you a reasonable fee for providing you a copy of your records. We may deny access, under certain circumstances. You may request that we designate a licensed health care professional to review the denial. We will comply with the outcome of the review.

Right to request an amendment. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for **ALTA VISTA WELLNESS CENTER** in your medical and billing records or any other of our records that are used by us to make decisions about you.

You are required to submit your request in writing to **ALTA VISTA WELLNESS CENTER** as explained at the end of this Notice, with an explanation as to why the amendment is needed. If we accept your request, we will tell you we agree, and we will amend your records. We cannot change what is in the record. We add the supplemental information by an addendum. With your assistance, we will notify others who have the incorrect or incomplete medical information. If we deny your request, we will give you a written explanation of why we did not make the amendment and explain your rights.

We may deny your request if the medical information (i) was not created by **ALTA VISTA WELLNESS CENTER** (unless the person or entity that created the medical information is no longer available to respond to your request); (ii) is not part of the medical and billing records kept by or for **ALTA VISTA WELLNESS CENTER**; (iii) is not part of the information which you would be permitted to inspect and copy; or (iv) is determined by us to be accurate and complete.

Right to an accounting of disclosures. You have the right to receive a list of the disclosures we have made of your medical information in the six years prior to your request. This list will not include every disclosure made, including those disclosures made for treatment, payment and health care operations purposes.

You are required to submit your request in writing to **ALTA VISTA WELLNESS CENTER** as explained at the end of this Notice. You must state the time/period for which you want to receive the accounting. The first accounting you request in a 12-month period will be free, and we may charge you for additional requests in that same period.

Right to request restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations.

To request a restriction, you must tell your caregivers or contact **ALTA VISTA WELLNESS CENTER** using the contact information listed at the end of this Notice. In some cases, you may be asked to submit a written request. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment or we are required or permitted by law to disclose it. We are allowed to end the restriction if we inform you that we plan to do so. If you request that we not disclose certain medical information to your health insurer and that medical information relates to a health care product or service for which we, otherwise, have received payment from you or on your behalf, and in full, then we must agree to that request.

Right to request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. If you want us to communicate with you in a special way, you will need to give us details about how to contact you. You also will need to give us information as to how billing will be handled. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information we have.

Right to be notified in the event of a breach. We will notify you if your medical information has been "breached," which means that your medical information has been used or disclosed in a way that is inconsistent with law and results in it being compromised.

Right to a paper copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

FUTURE CHANGES TO ALTA VISTA WELLNESS CENTERS' PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change **ALTA VISTA WELLNESS CENTERS'** privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. A at any time you may request a copy of the Notice currently in effect.

Use of e-mail. If you choose to communicate with us via email, we may respond to you in the same manner in which the communication was received and to the same email address from which you sent your email. Before using email to communicate with us, you should understand that there are certain risks associated with the use of email. It may not be secure, which means it could be intercepted and seen by others. In addition, there are other risks associated with use of email, such as misaddressed/misdirected messages, email accounts that are shared with others, messages that can be forwarded on to others, or messages stored on portable electronic devices that have no security.

Additionally, you should understand that use of email is not intended to be a substitute for professional medical advice, diagnosis or treatment. Email communications should never be used in a medical emergency.

QUESTIONS OR COMPLAINTS

If you believe that your privacy rights have not been followed as directed by applicable law or as explained in this Notice, you may file a complaint with us. Please send any complaint to the ALTA VISTA WELLNESS CENTER Privacy Office at the address provided below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. ***You will not be penalized for filing a complaint.***

If you have questions or would like further information about this Notice, please contact:

ALTA VISTA WELLNESS CENTER
401 Shiloh Dr., Suite 9
Laredo, TX 78045
Phone: 956-791-8235
Fax: 956-791-8239
E-mail: algohealthinc@gmail.com

NON-DISCRIMINATION NOTICE

ALTA VISTA WELLNESS CENTER complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ACKNOWLEDGEMENT

I acknowledge and understand that as a patient of this clinic, I reserve the right to have my personal health information kept confidential at all times and that only in certain circumstances, which are mentioned in the Health Information Privacy Notice, will my information may be disclosed to selected individuals.

By signing below, I certify that I have read and/or received a copy of the Health Information Privacy Notice (upon request).

If any changes are made to this Notice, I will be informed and provided with a copy.

_____ _____

Patient / Guardian Name (Print) **Relationship to Patient**

_____ _____

Patient / Guardian Signature **Date**